

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02830

CERTIFICATE OF DEATH

02840

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Sev. yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		d. STREET ADDRESS 216 Washington Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 216 Washington Street				d. STREET ADDRESS 216 Washington Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Julia		First	Middle	Lost	4. DATE OF DEATH March 29, 1957	Month	Day	Year
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 22, 1921		9. AGE (In years last birthday) 35 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 3 Days 0 Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Food Packing		11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William Spicer		14. MOTHER'S MAIDEN NAME Clara Harris						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-10-6564		17. INFORMANT Frances Harris, Cambridge, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis, abdominal						INTERVAL BETWEEN ONSET AND DEATH 142		
170X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO metastases from ca breast left						4 yrs		
(c) DUE TO								
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) loss of wt., general debility, & anemia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) Cambridge, Md.		(State) Md.
21. I certify that I attended the deceased from Jan 29, 1957 to Mar 29, 1957 , that I last saw the deceased alive on Mar 29, 1957 , and that death occurred at 8 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Cambridge, Md.		DATE SIGNED Apr 1, 57
ACTUAL SIGNATURE James C. Thompson								
PHYSICIAN'S NAME (Type) John M. Thompson								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/2/1957		22c. NAME OF CEMETERY OR CREMATORIUM Linas Road Cemetery		22d. LOCATION (City, town, or county) Linas Road, Maryland		(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE John M. Thompson		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR John M. Thompson		24b. REGISTRAR'S SIGNATURE John M. Thompson		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF DEFENSE
CERIFICATE OF DEATH

BUREAU V. S.

APR 3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02841

02831 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb Life			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Md. Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge			
3. NAME OF -DECEASED (Type or print) Heward		First E.	Middle (Ball) Last Ball		
4. DATE OF DEATH March 12 1957		Month March	Day 12		
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		
8. DATE OF BIRTH Feb. 2, 1883		9. AGE (in years last birthday) 74 yrs.	10. IF UNDER 1 YEAR Months 11. IF UNDER 24 HRS. Days		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Cook		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) Maryland		
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomana Ball			
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mrs. Hattie M. Ball			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		Address Coronary Occlusion			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		INTERVAL BETWEEN ONSET AND DEATH 1 Hr.			
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE <i>John Mace Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 3/18/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-17-57	22c. NAME OF CEMETERY OR CREMATORIAL WAUGH	22d. LOCATION (City, town, or county) CAMBRIDGE, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeON W. HENRY - CAMBRIDGE		ADDRESS	24a. REC'D BY REGISTRAR DATE 3/18/57		24b. REGISTRAR'S SIGNATURE John Mace Jr.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

MAR 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02842

02832

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md.		c. LENGTH OF STAY IN 1b 4 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hoopersville, Md.		d. STREET ADDRESS Hoopersville, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Hattie		First Middle Nelson		Last Booze		4. DATE OF DEATH March	Month 1	Day 19	Year 57
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 5, 1885		9. AGE (In years lost birthday) 72	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Hoopersville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Edmond R. Nelson				14. MOTHER'S MAIDEN NAME Sadie Lewis					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Oscar Nelson		Address Hoopersville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 203X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Multiple Sclerosis				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from 2-24, 1957, to 3-1, 1957, that I last saw the deceased alive on 3-1, 1957, and that death occurred at 9 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE J. B. BURMAN M.D.						ADDRESS (Street, city or town, state) Cambridge		DATE SIGNED 3-2-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 3, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Mem. Park		22d. LOCATION (City, town, or county) Cambridge		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE 3/4/57		24b. REGISTRAR'S SIGNATURE John Macad			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 8
REGELVED

MAR 7 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02843

02833

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		d. STREET ADDRESS 9 School House Lane			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9 Schoolhouse Lane						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary		First	Middle	Last	4. DATE OF DEATH March	Month	Day	Year	
5. SEX Female		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1891	9. AGE (In years lost birthday) 65 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Dor-Co-Md.		12. CITIZEN OF WHAT COUNTRY? USA.			
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME Hester Dutton							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None		17. INFORMANT Randolph Hughes, Cambridge, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		DUE TO Arteriosclerotic heart disease				INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last.		(b) DUE TO Arteriosclerotic heart disease							
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19		Month	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from January 10, 1956 , to March 1, 1957 , that I last saw the deceased alive on March 1, 1957 , and that death occurred at 7:30 PM , from the causes and on the date stated above.						ADDRESS (Street, city or town, state)			DATE SIGNED
ACTUAL SIGNATURE 									3-3-57
PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-3-57		22c. NAME OF CEMETERY OR CREMATORIUM Bethel Cemetery		22d. LOCATION (City, town, or county) Cambridge, Dor-		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS High St - Cambridge, Md.		24a. REC'D BY REGISTRAR 3/6/57		24b. REGISTRAR'S SIGNATURE John Maca Jr.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
FEB 8 1957

BUREAU V.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be attached for use as the burial-transit Permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02844

02853

CERTIFICATE OF DEATH

Reg. Dist. No.

116

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Worcester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN lb 42 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin 23 x 02		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First CALVIN	Middle W.	Lost BURBAGE	4. DATE OF DEATH March 26 1957	Month March	Day 26	Year 1957
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5/14/79	9. AGE (In years last birthday) 77 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. MIN. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mechanic		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME James Burbage		14. MOTHER'S MAIDEN NAME Mary Priscilla (maiden name unknown)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. 120 17. INFORMANT Eastern Shore State Hospital records		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) General arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenia, hebephrenic type 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. p. p. m.	Month 19	Day	20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Buckingham	20f. (City or town) Berlin	(County) Md.	(State) 3-26-57	
21. I certify that I attended the deceased from Mar 15, 1953 to Mar 26, 1957 , that I last saw the deceased alive on Mar 26, 1957 , and that death occurred at 2:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) S. H. Cambridge Md. DATE SIGNED 3-26-57								
ACTUAL SIGNATURE Thomas J. Dredge M.D.								
PHYSICIAN'S NAME (Type) Thomas J. Dredge								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-28-57	22c. NAME OF CEMETERY OR CREMATORIUM Buckingham	22d. LOCATION (City, town, or county) Berlin					
23. FUNERAL DIRECTOR'S SIGNATURE Anna a Burbage Berlin		ADDRESS MAR 29 1957	24a. REC'D BY REGISTRAR John Max Jr.	24b. REGISTRAR'S SIGNATURE				

CERTIFICATE OF DEATH

BUREAU V. A.

MAR 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02834 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02845

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL) Cambridge		b. COUNTY Dorchester	
c. LENGTH OF STAY IN 1b 7 mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Md. Hospital		d. STREET ADDRESS 6 Sinclair Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Cecil	Middle	Last Clark
4. DATE OF DEATH	Month March	Day 31	Year 1957
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1909
9. AGE (in years to birthday) 43 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY food packing	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO.	
17. INFORMANT Annie May Clark		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
19. INTERVAL BETWEEN ONSET AND DEATH 20 min		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <i>John Moore Jr.</i>		DATE SIGNED	
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/4/57	
22c. NAME OF CEMETERY OR CREMATORIAL Waugh cemetery		22d. LOCATION (City, town, or county) Cambridge	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Herbert M. St. Leger Jr.</i>		24a. REC'D BY REGISTRAR DATE 4/1/57	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>J. R. Moore Jr.</i>	

BULEAU V. S.
JULY 2 1957
1670

Yours & much
affection,

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02846

02853

CERTIFICATE OF DEATH

Reg. Dist. No. 110

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be checked for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsburg - Rural		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsburg - Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Near Zion		d. STREET ADDRESS Near Zion		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Marion		First Wilmer	Middle Corkran	4. DATE OF DEATH March 20	Month 1957	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH January 21, 1869	9. AGE (In years lost birthday) 88 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Captain		10b. KIND OF BUSINESS OR INDUSTRY Steam Vessels		11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Christopher C. Corkran				14. MOTHER'S MAIDEN NAME Eliza A. Andrew			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Raymond F. Corkran, Williamsburg, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last				Anu C. Corkran Failure of Primary Eclips		INTERVAL BETWEEN ONSET AND DEATH 2 w 1/2	
(b) DUE TO Generalized Arteriosclerosis						25 y 1/2	
(c) Arteriosclerosis Heart Disease						20 y 1/2	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Preston		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/21, 1957, to 01/20, 1957, that I last saw the deceased alive on 3/20, 1957, and that death occurred at 7:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Preston Maryland							
ACTUAL PHYSICIAN'S NAME (Type) Harold B. Pummer		M.D.		DATE SIGNED 3/21/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 23, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Hill Crest Cemetery		22d. LOCATION (City, town, or county) Federalsburg, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Fram, Son, Federalsburg, Maryland				ADDRESS		24a. REC'D BY REGISTRAR DATE March 23, 1957	
						24b. REGISTRAR'S SIGNATURE J. J. Fram, Son, Federalsburg, Maryland	

BUREAU V. S.

MAR 29 1951

KEL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
02835

CERTIFICATE OF DEATH

02847

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b 2 1/2 Years		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fishing Creek, Md.								
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION 134 Locust St.		d. STREET ADDRESS Fishing Creek, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) Edith	First	Middle Meekins	Last Creighton	4. DATE OF DEATH March	Month	Day 21	Year 1957					
S SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1873	9. AGE (In years last birthday) 84 83 yrs.	10. IF UNDER 1 YEAR Months 8	11. IF UNDER 24 HRS. Days 83	12. IF UNDER 24 HRS. Hours 8					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Fishing Creek, Md.		12. CITIZEN OF WHAT COUNTRY? USA						
13. FATHER'S NAME Samuel G. Meekins		14. MOTHER'S MAIDEN NAME Rebecca Tyler		Address 134 Locust St.								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Homer Murphy		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (b) 31X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral Hemorrhage Generalized Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 8 days. 10 yrs.						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
21. I certify that I attended the deceased from 1/20/57 to 3/21/57 , that I last saw the deceased alive on 3/15/57 , and that death occurred at 10:00 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 136 Race St. Cambridge		DATE SIGNED 3/23/57								
ACTUAL SIGNATURE Lawrence Maryanov		M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 24, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Hoosier Memorial Church		22d. LOCATION (City, town, or county) Fishing Creek, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE 3/25/57		24b. REGISTRAR'S SIGNATURE John M. Compton						

RECEIVED
BUREAU V. S

APR 1 1957

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
02836 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02848
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge-Md.-Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First James	Middle	Last Dorsey
4. DATE OF DEATH	Month 3	Day 5	Year 1957
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-2-24
9. AGE (in years last birthday) 32 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Laborer	
11. BIRTHPLACE (State or foreign country) Dor-Co-Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Dorsey		14. MOTHER'S MAIDEN NAME Hattie Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unkn		16. SOCIAL SECURITY NO. 214-16-4949 17. INFORMANT Mrs Hattie Dorsey-Cambridge, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 470X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		19. INTERVAL BETWEEN ONSET AND DEATH 1 week	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Gastroenteritis Cirrhosis of Liver		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Cirrhosis of Liver	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>		DATE SIGNED 3/11/57	
ACTUAL SIGNATURE <i>John Mace Jr.</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) John Mace Jr.	22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-10-57
22c. NAME OF CEMETERY OR CREMATORIAL Thompson-Town-Cemetery	22d. LOCATION (City, town, or county) Thompson Town Md.		
23. FUNERAL DIRECTOR'S SIGNATURE H.M. SIC/FIR JR. - High St-Camb-Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE 3/11/57	24b. REGISTRAR'S SIGNATURE <i>John Mace Jr.</i>

RECEIVED

BUNAU V. S

JAR

1930. 12. 25.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02849

02837

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.			2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Md.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.			b. COUNTY Dorchester Co.		
c. LENGTH OF STAY IN 1b 2 Weeks			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital			d. STREET ADDRESS E. Appleby Ave.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Linnie		First Hurley	Middle Elzey	Last Elzey	4. DATE OF DEATH Mar. 11, 1957
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 21, 1897	9. AGE (In years last birthday) 59 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salvation Army		10b. KIND OF BUSINESS OR INDUSTRY Salvation Army		11. BIRTHPLACE (State or foreign country) Talbot Co.	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME George Hurley			14. MOTHER'S MAIDEN NAME Gertrude Allen		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None		
17. INFORMANT Florence Abbott			Address E. Appleby Ave.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Coronary Heart Disease (c)			INTERVAL BETWEEN ONSET AND DEATH 5 min		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month. Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____ to _____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above. ACTUAL SIGNATURE Lawrence Maryanov M.D.		ADDRESS (Street, city or town, state) 136 Race St. DATE SIGNED			
22. PHYSICIAN'S NAME (Type) Lawrence Maryanov		Cambridge Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 11, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Dor. Mem. Park		22d. LOCATION (City, town, or county) Cambridge Md.
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		24a. REC'D BY REGISTRAR DATE 3/15/57 John MacAuliffe			
VS AIS (4) ISM 9/55		24b. REGISTRAR'S SIGNATURE			

BUREAU Y. S.

NOV 1 1957



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02838

02850

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.				2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Md.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.				b. COUNTY Dorchester Co.			
c. LENGTH OF STAY IN 1b Home				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home 117 Locust St.				d. STREET ADDRESS 117 Locust St.			
3. NAME OF DECEASED (Type or print) Daniel				First Daniel	Middle 	Last Garner	4. DATE OF DEATH March 1, 1957
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 2, 1867	9. AGE (In years from birthday) 89	10. IF UNDER 1 YEAR Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Merchant		11. BIRTHPLACE (State or foreign country) Suwalki Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Garner				14. MOTHER'S MAIDEN NAME Jennie Garner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT David I. Jacobson		Address Cambridge Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Uremia				6 days			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Arteriosclerotic cardio vascular renal disease				10 years+			
DUE TO (c) Arteriosclerosis, generalized				10 years+			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. --- 19		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-27-57 , 19, to 3-1-57 , 1957, that I last saw the deceased alive on 3-1-57 , and that death occurred at 8:35 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Eldridge H. Wolff M.D. 15 Locust Street, Cambridge, Md. DATE SIGNED 3-2-57							
ACTUAL SIGNATURE <i>Eldridge H. Wolff</i>		PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 3, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Hebrew Friendship Cemetery		22d. LOCATION (City, town, or county) Baltimore, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service Cambridge, Md.				24a. REC'D BY REGISTRAR DATE 3/2/57		24b. REGISTRAR'S SIGNATURE <i>John Macauley</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SCHEAU V. S

APR 22 1957

6050-100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
02839 CERTIFICATE OF DEATH

02851

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester			MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge			c. LENGTH OF STAY IN 1b Life			b. COUNTY Dorchester		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Lottie		First Lottie	Middle Jones	Last Goslee	4. DATE OF DEATH 3	Month 3	Day 16	Year 1957
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8-21-1895		9. AGE (In years last birthday) 61 yrs.	10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 11. BIRTHPLACE (State or foreign country) Dor-Co-Md		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer			10b. KIND OF BUSINESS OR INDUSTRY factory			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William James				14. MOTHER'S MAIDEN NAME Susan Pinkett				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 212-18-6292		17. INFORMANT Levin Fisher-Vienna, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 480.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Coronary Heart Disease								
INTERVAL BETWEEN ONSET AND DEATH								
(b) DUE TO Coronary Heart Disease								
(c) Myocardial infarction								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 1b.]					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 0			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 1954 , to March 16, 1957 , that I last saw the deceased alive on March 16, 1957 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED								
ACTUAL SIGNATURE <i>J. Edwin Fassett</i>								
PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-20-57		22c. NAME OF CEMETERY OR CREMATORIUM Vienna Cemetery		22d. LOCATION (City, town, or county) Vienna-Dor-Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert H. Fassett</i>				ADDRESS High St-Cambridge, Md.		24a. REC'D BY REGISTRAR 3/23/57		
						24b. REGISTRAR'S SIGNATURE <i>Mac</i>		

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PUERTO V. S.

13

MANSON

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02851 CERTIFICATE OF DEATH

Reg. Dist. No. 290

02852

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND			2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE Maryland b. COUNTY Talbot					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb 9 mo. 16 das.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital			d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Ruth		First Evelyn	Middle	Last Greenhawk	4. DATE OF DEATH	Month March	Day 8	Year 1957
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-9-97		9. AGE (In years last birthday) 59 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland		
13. FATHER'S NAME Nathaniel Clifton			14. MOTHER'S MAIDEN NAME Annie Daly			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. -			17. INFORMANT Address RECORDS - Eastern Shore State Hospital		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Pneumonia 41-5 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 5 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Psychoneurotic Disorder, Conversion Reaction			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)			
21. I certify that I attended the deceased from May 23, 1956, to March 8, 1957, that I last saw the deceased alive on March 8, 1957, and that death occurred at 6:00 a. m. from the causes and on the date stated above.			ADDRESS (Street, city or town, state)			DATE SIGNED 3-8-57		
ACTUAL SIGNATURE <i>Simon Virkutis</i>			M.D. E.S.S. Hospital, Cambridge, Md.					
PHYSICIAN'S NAME (Type) Dr. Simon Virkutis								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 11, 1956		22c. NAME OF CEMETERY OR CREMATORIAL Spring Hill Cemetery		22d. LOCATION (City, town, or county) Easton, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Merle L. Newman, Son</i>			ADDRESS <i>Easton, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>3/11/57</i>		24b. REGISTRAR'S SIGNATURE <i>John H. Morris</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 15 1955

BUREAU N.Y.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02855

Item 4 File

CERTIFICATE OF DEATH

Reg. Dist. No.

02853

1. PLACE OF DEATH a. COUNTY <i>Dorchester</i>		2. USUAL RESIDENCE (Where deceased lived a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St. Michaels</i>		b. COUNTY <i>Dor</i>	
c. LENGTH OF STAY IN 1b <i>all life</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St. Michaels</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Academy</i>		d. STREET ADDRESS <i>Academy</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)	First <i>Floyd</i>	Middle <i>N.</i>	Last <i>Harper</i>	4. DATE OF DEATH Month Day Year
5. SEX <i>male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 31, 1889</i>	9. AGE (In years last birthday) yrs. <i>67</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, several if retired) <i>Insured Biscuit Rkt.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>nd.</i>		10c. BIRTHPLACE (State or foreign country) <i>J. S. C.</i>

10d. CIVIL STATUS <i>Married</i>	10e. DATE OF DEATH <i>March 28, 1957</i>	10f. IF UNDER 1 YEAR Months Days	10g. IF UNDER 24 HRS Hours Min.
-------------------------------------	---	--	---------------------------------------

13. FATHER'S NAME <i>Thomas B. Harper</i>	14. MOTHER'S M AIDEN NAME <i>Rebecca Medford</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>163X</i>	16. SOCIAL SECURITY NO. <i>123-45-6789</i>	17. INFORMANT <i>Mr. Floyd N. Harper, St. Michaels, Md.</i>
--	---	--	---	--

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Dehydration + Acidosis</i>	INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i>
DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.</i>	
(b) DUE TO <i>Carcinoma of lung</i>	1 year +
(c)	

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
--	--	--

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
---	--	--	--

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
---	---	--	---

21. I certify that I attended the deceased from <i>January</i> , 19 <i>56</i> , to <i>March 28</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>March 27</i> , 19 <i>57</i> , and that death occurred at <i>4:00 AM</i> , from the causes and on the date stated above.	ADDRESS (Street, city or town, state) <i>St. Michaels, Md.</i>	DATE SIGNED <i>3/28/57</i>
---	---	-------------------------------

ACTUAL SIGNATURE <i>W.C. Harrison MD</i>	M.D.
--	------

PHYSICIAN'S NAME (Type) <i>W.C. Harrison, M.D.</i>	22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial 3/30/57</i>	22b. DATE THEREOF <i>3/30/57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Washington</i>	22d. LOCATION (City, town, or county) <i>St. Michaels, Md.</i>
--	---	-------------------------------------	---	---

23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Mallon by C. J. Market</i>	ADDRESS <i>101 S. Hollingsby Rd. 1. Market</i>	24a. REC'D BY REGISTRAR DATE <i>PR 3 1957</i>	24b. REGISTRAR'S SIGNATURE <i>John J. Mallon</i>
---	---	---	---

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. S.

APR 5 1971

REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02854

02855 CERTIFICATE OF DEATH

Reg. Dist. No.

116

1. PLACE OF DEATH a. COUNTY		Dorchester Eastern Shore State Hosp.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE		Md. Pocomoke		b. COUNTY		Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Crownsville		1 Mo 3da		c. LENGTH OF STAY IN 1b		Pocomoke		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Pocomoke	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Eastern Shore State Hosp.				d. STREET ADDRESS		RD-2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		John H. Heel				4. DATE OF DEATH		Mar 2 1957		Month		Day Year	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		6-7-1880		9. AGE (In years lost 1st birthday)		76 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
Farmer		Farmer		Snow Hill Md.		U.S.A.							
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME											
John Heel		Jane Pettitt											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address							
No		None		Edmund Heel - (Economic) Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Chronic Myocarditis				1-27-57							
422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) Arterio-sclerosis - Generalized				1-27-57							
		DUE TO (c) Paraplegia (Throat)				3-2-57							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Edema Lower Extremities				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		None									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1-27-1957 to 3-2-1957 that I last saw the deceased alive on 3-1-1957, and that death occurred at 12:15 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state)							
ACTUAL SIGNATURE		M.D.		Edwin Ward		DATE SIGNED							
PHYSICIAN'S NAME (Type)		Edwin J. Ward		Eastern Shore State Hosp.									
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county) (State)							
Burial		3-5-57		PARKSLEY CEMETERY		PARKSLEY, VIRGINIA							
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE							
Henry H. Watson		Pocomoke, Md.		MAR 7 1957		John Macay							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be attached for use as the burial-transit Permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

LIBRARY

MAR 9 1957

LIBRARY

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form M3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

16

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

325 FAIRY ST.

1957

MAIL

325 FAIRY ST.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02856

02840

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Dorchester Maryland		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Cambridge Maryland		2 days	
d. NAME OF HOSPITAL (If not a hospital, give street address) OR INSTITUTION		e. STREET ADDRESS	
Combridge Maryland		Middle	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
Herman Wendell Hurst		Wendell	Hurst
4. DATE OF DEATH		Month	Day
		3	13
		Year	1957
5. SEX		6. ETHNIC RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
Male		White	18/1884 75
8. DATE OF BIRTH		9. AGE (In years to nearest birthday) yrs.	10. IF UNDER 1 YEAR Months Days Hours Min
10a. US LAB OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. PLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
During most of working life even if retired)		Maryland U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Lorenzo Hurst		Sarah J. Christopher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Lorraine Hanks Hurst, Vienna	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		19. INTERVAL BETWEEN ONSET AND DEATH	
200.1 Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last.		Internal hemorrhage (Thoracic) 1 day	
(b) DUE TO		Lymphosarcoma left lung 2	
(c) DUE TO		Leukemia - lymphatic ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/1/1957 to 3/13/1957, that I last saw the deceased alive on 3/13/1957, and that death occurred at 9 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE		H. J. Hanks M.D. 104 Locust St. 3/15/57	
PHYSICIAN'S NAME (Type)		W. H. Hanks M.D. Cambridge Md.	
22a. CERIAL, CREMATION, 22b. DATE THEREOF REMOVAL (SPECIFY)		22c. NAME OF CEMETERY OR CREMATORIAL	
Cerial, 3/16/57		Vienna	
22d. LOCATION (City, town, or county)		(State)	
Vienna Md.			
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE	
F. J. Hanks		John Grace Jr. 3/16/57	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the above papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SUREAU V. 2

111 AR 1135



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
02841 CERTIFICATE OF DEATH

02857

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Dor.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b 5 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East New Market Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital		d. STREET ADDRESS East New Market Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Mariam	Middle Simpson	Last Jackson	4. DATE OF DEATH Mar.	Month 11	Day 11	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 31, 1913	9. AGE (In years last birthday) 43	10. IF UNDER 1 YEAR, IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shirt Factory		10b. KIND OF BUSINESS OR INDUSTRY Shirt Factory		11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Andrew Simpson		14. MOTHER'S MAIDEN NAME Mary Della					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-32-9057		17. INFORMANT Harry Jackson		Address Hurlock Md.	
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Memento Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Chronic Nephritis (c)						INTERVAL BETWEEN ONSET AND DEATH 5 days years?	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D.		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/11, 1957, to 3/11, 1957, that I last saw the deceased alive on 3/11, 1957, and that death occurred at 8 M, from the causes and on the date stated above. ACTUAL SIGNATURE W. H. Hanks PHYSICIAN'S NAME (Type) W. H. Hanks		ADDRESS (Street, city or town, state) 104 Locust Cambridge Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 14, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Dor. Mem. Park		22d. LOCATION (City, town, or county) Cambridge Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR DATE 3/15/57		24b. REGISTRAR'S SIGNATURE John Mace Jr.	

7. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-trust permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BEREAU Y.

1957

BEREAU Y.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02842

CERTIFICATE OF DEATH

02858

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 504 High Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
3. NAME OF DECEASED (Type or print) Thomas		First Henry	Middle Jackson
4. DATE OF DEATH Mar. 15, 1957		5. SEX Male	6. COLOR OR RACE Negro
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 16, 1851	
9. AGE (In years last birthday) 105		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Pinkett		14. MOTHER'S MAIDEN NAME Annie A. Jackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. *****	
17. INFORMANT Address Sudie Gibson, Cambridge, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? NO		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19	
20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Cambridge (County) Md. (State) Md.	
21. I certify that I attended the deceased from 12/29/1956 to 3/15/1957 that I last saw the deceased alive on 3/14/1957 and that death occurred at Cambridge, Md. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE JOHN MACE JR.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/19/1957	
22c. NAME OF CEMETERY OR CREMATORIUM Waugh Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE HAROLD W. MACE JR.		24a. REC'D BY REGISTRAR DATE 3/19/57	
ADDRESS Cambridge, Md.		24b. REGISTRAR'S SIGNATURE John Mace Jr.	

TO HOSPITAL OR ATTEND PHYSIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REAU V. S.

11-18-81

REAU V. S.

02853

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester County		2. USUAL RESIDENCE (Where deceased lived if institutional, Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock		c. LENGTH OF STAY IN 1b 6 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Goldsboro St. Easton, Md.	
d. STREET ADDRESS		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Marjorie	Middle S. Jaynes.	4. DATE OF DEATH 3/20.57
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 1, 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Maryland.
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Harten.	
14. MOTHER'S MAIDEN NAME "No records"		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ne	
16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Adam Royer. Easton, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 5 minutes	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause if lost. (b) DUE TO General Arteriosclerosis		5 years +	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Easton		(County) (State) Wicomico Co. Md.	
21. I certify that I attended the deceased from March 20, 1957 , to March 20, 1957 , that I last saw the deceased alive on March 20, 1957 , and that death occurred at 9:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. C. Harrison MD		ADDRESS (Street, city or town, state) Hurlock, Md.	
PHYSICIAN'S NAME (Type) W. C. Harrison MD		DATE SIGNED 3/22/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 22, 57.	
22c. NAME OF CEMETERY OR CREMATORIUM Oxford.		22d. LOCATION (City, town, or county) Oxford, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Dredick		24a. REC'D BY REGISTRAR DATE Mar 22 1957	
ADDRESS Easton Md		24b. REGISTRAR'S SIGNATURE J. J. Dredick	

RECEIVED
FEBRUARY 25, 1967

MAR 2 1967

FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

02859

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE	
DORCHESTER MARYLAND		MARYLAND b. COUNTY WORCESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE		c. LENGTH OF STAY IN lb 1 mo, 26 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTERN SHORE STATE HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SNOW HILL	
d. STREET ADDRESS		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH Month Day Year	
First OLIVER Middle EBER Last LEONARD		MARCH 9 1957	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/9/1873	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER		10b. KIND OF BUSINESS OR INDUSTRY Newspaper	
11. BIRTHPLACE (State or foreign country) COLORADO		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME PERCY A. LEONARD		14. MOTHER'S MAIDEN NAME IDA C. CRITTENDEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? YES		16. SOCIAL SECURITY NO. WWI 217-09-0144	
17. INFORMANT EASTERN SHORE STATE HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 1 year	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)		ARTERIOSCLEROTIC HEART DISEASE	
DUE TO (c)		GENERALIZED ARTERIOSCLEROSIS 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DIABETES MELLITUS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-11, 1957 to 3-9, 1957, that I last saw the deceased alive on 3-9, 1957, and that death occurred at 12:25 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE GEORGE E. CURRIER M.D.		CAMBRIDGE MD.	
PHYSICIAN'S NAME (Type)		EASTERN SHORE STATE HOSPITAL	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 11/57		22b. DATE THEREOF 11/57	
22c. NAME OF CEMETERY OR CREMATORIAL Gresham Cemetery		22d. LOCATION (City, town, or county) Snow Hill Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Corman F. Dennis		ADDRESS Snow Hill Md.	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE John MacLean	
DATE MAR 13 1957		DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

RECEIVED
MURKIN, V. L.

MAR 12 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02861

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b lyr. 2 mo. 11	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) da. Caroline County	
3. NAME OF DECEASED (Type or print) First George		d. STREET ADDRESS R. F. D.	
4. DATE OF DEATH Month 3 Day 9 Year 1957		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> Rural	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1889
10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY during most of working life, even if retired) Unk.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? Unk.		13. FATHER'S NAME Jessie Passawters	
14. MOTHER'S MAIDEN NAME Eliza Legates		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. none		17. INFORMANT Gilbert Passawters Address Denton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO <input checked="" type="checkbox"/> <i>Cardinal Arteric - Sclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chr. Brain Symdrome w. psychotic recations		3 months	
DUE TO <input type="checkbox"/> (c) Malnunitrition			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/3/1957, to 3/9/57, 19, that I last saw the deceased alive on 3/7/1957, and that death occurred at 11.10 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Edwin J. Ward</i>		ADDRESS (Street, city or town, state) Cambridge, Maryland DATE SIGNED	
PHYSICIAN'S NAME (Type) Edwin J. Ward		Eastern Shore State Hospital	
22a. BURIAL, CREMATION, REMOVAL (Specify) 3/13/1957	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL Bowers Cemetery	22d. LOCATION (City, town, or county) (State) Federalsburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Ward</i>		ADDRESS Federalsburg, Md.	24a. REC'D BY REGISTRAR DATE 3/13/1957
			24b. REGISTRAR'S SIGNATURE <i>John W. Ward</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.
RECEIVED
MAR 1 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
02843 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02862

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Md.		b. COUNTY Dorchester Co.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		d. STREET ADDRESS E. Appleby Ave.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) In car on Holland ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Leon		First	Middle	Last	4. DATE OF DEATH Mar. 29, 1957	Month	Day	Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1905	9. AGE (In years last birthday) 51	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Cambridge Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Jos eph Peters		14. MOTHER'S MAIDEN NAME Nettie Davey						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Leon Peters E. Appleby Ave.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary occlusion				Instant		
420.1 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.		DUE TO						
(b)		DUE TO						
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>								
ACTUAL SIGNATURE <i>John Mace Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3/26/57				
EXAMINER'S NAME (Type) John Mace Jr.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 27, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Park		22d. LOCATION (City, town, or county) Cambridge		
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge Md.		24a. REC'D BY REGISTRAR DATE 3/27/57		24b. REGISTRAR'S SIGNATURE <i>John Mace Jr.</i>		

REGEL V. ELLIOTT

APR 1 1957

DUKEAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02863

02844 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Dorchester Co.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		c. LENGTH OF STAY IN 1b 1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital			d. STREET ADDRESS 119 Talbot Ave.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Howard		First Compton	Middle Reed	Last March	DATE OF DEATH Month 27, 1957 Day Year
4. SEX Male		5. COLOR OR RACE White	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. B. DATE OF BIRTH Mar. 26, 1900	8. AGE (In years last birthday) 57 yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Produce Broker		10b. KIND OF BUSINESS OR INDUSTRY Produce Broker		11. BIRTHPLACE (State or foreign country) Neck Dist. Dor. Co.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Howard C. Reed			14. MOTHER'S MAIDEN NAME Grace Warfield		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 17. INFORMANT 218-20-6803 Margaret Marie Reed Cambridge Md Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (b). DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Coronary occlusion Coronary heart disease Diabetes mellitus					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 136 Race St	(County) Cambridge Md (State)
21. I certify that I attended the deceased from <u>3/18/57</u> , 19 <u>57</u> , to <u>3/27</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/27</u> , 19 <u>57</u> , and that death occurred at <u>9 AM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE Lawrence Maryanov M.D. ADDRESS (Street, city or town, state) 136 Race St DATE SIGNED 3/28/57					
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 29, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Greenlawn Cemetery	22d. LOCATION (City, town, or county) Cambridge Md.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service			ADDRESS Cambridge Md.	24a. REC'D BY REGISTRAR DATE 3/29/57	24b. REGISTRAR'S SIGNATURE John M. Compte Jr.

TO HOSPITAL OR ATTENDANT PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 1 1964

REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02864

02861

CERTIFICATE OF DEATH

Reg. Dist. No. 110

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rhodesdale → Rural		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Vienna Road		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X: Rhodesdale - Rural	
3. NAME OF DECEASED (Type or print) First Charlie Middle Linwood Last Rideout		4. DATE OF DEATH March 7 Month 7 Day Year 57 19	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> February 27, 1887	9. AGE (in years from birthday) 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	10c. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland
13. FATHER'S NAME John Johnson		14. MOTHER'S MAIDEN NAME Katie Lake	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-07-9985	17. INFORMANT Address Mrs. Mildred Jones, Rhodesdale, Md., R.F.D.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1yr + 1yr +	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 5</u> , 1957, to <u>March 7</u> , 1957, that I last saw the deceased alive on <u>March 5</u> , 1957, and that death occurred at 10:30PM, from the causes and on the date stated above. ACTUAL SIGNATURE W.C. Harrison PHYSICIAN'S NAME (Type) W.C. Harrison M.D.		ADDRESS (Street, city or town, state) Hurstock, Md. DATE SIGNED 3/7/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 11, 1957	
22c. NAME OF CEMETERY OR CREMATORIUM Reid's Grove Cemetery		22d. LOCATION (City, town, or county) Near Rhodesdale, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR DATE March 11, 1957	
24b. REGISTRAR'S SIGNATURE Mrs. Chas. W. Hastings			

RECEIVED

MAR 14 19

19

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02865

02845

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md.		c. LENGTH OF STAY IN 1b 10 Days		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Md.		f. STREET ADDRESS 12 Glasgow Ave.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Frank	Middle	Last Robbins	4. DATE OF DEATH March	Month	Day 7	Year 1957		
S SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH June 17, 1886	9. AGE (In years last birthday) 70	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Director of Public Relations		10b. KIND OF BUSINESS OR INDUSTRY Cambridge Md.		11. BIRTHPLACE (State or foreign country) Cambridge Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James Robbins			14. MOTHER'S MAIDEN NAME Mary Jane Cook			Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. World War I 220-01-76		17. INFORMANT Mr. William Shaw		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (b) DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the under- lying cause (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes			INTERVAL BETWEEN ONSET AND DEATH 3 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fracture						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cambridge		(County) Md.	(State) 2-8-57
21. I certify that I attended the deceased from 19 , 1957, to 2-8-57 , that I last saw the deceased alive on 3-7 , 1957, and that death occurred at 8:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cambridge Md. DATE SIGNED 2-8-57									
ACTUAL SIGNATURE W. K. Braumann		PHYSICIAN'S NAME (Type) W. K. Braumann							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 9, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Mem. Park		22d. LOCATION (City, town, or county) Cambridge		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service Cambridge Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE 3/22/57 John Macd.		24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. POSTAL SERVICE

MAR 03 1957

KELLOGG

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02846

Reg. Dist. No.

02846 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Dorchester		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b entire life		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		d. STREET ADDRESS 405 Trenton St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Nancy	Middle Lee	Last Rosetta	4. DATE OF DEATH March 15, 1957	Month 19	Day	Year		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1957	9. AGE (In years last birthday) yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Cambridge		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Charles B. Rosetta Jr.			14. MOTHER'S MAIDEN NAME Naomi Willey						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) No		17. INFORMANT None		Address Charles B. Rosetta Jr., 405 Trenton St., Cambridge			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> <u>lying cause last.</u> (b) <u>Anoxemia due to prolapsed cord</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 day			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) ---							
20c. TIME OF INJURY Hour a. m. p. m.	Month --	Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	20f. (City or town) ---	(County)	(State)		
21. I certify that I attended the deceased from <u>March 14</u> , 1957, to <u>March 15</u> , 1957, that I last saw the deceased alive on <u>March 15</u> , 1957, and that death occurred at <u>3:50AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED									
ACTUAL SIGNATURE	<u>Eldridge H. Wolff</u> M.D. 15 Locust Street, Cambridge, Md. 3-16-57								
PHYSICIAN'S NAME (Type)	Eldridge H. Wolff, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF March 16, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Greenlawn Cemetery	22d. LOCATION (City, town, or county) Cambridge, Md. (State)						
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth R. Leonard</u>	ADDRESS Cambridge, Md.	24a. REC'D BY REGISTRAR DATE 3/20/57	24b. REGISTRAR'S SIGNATURE <u>John M. M. Jr.</u>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

REAU Y.

MAR 20 1967

REFUGEE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02863

CERTIFICATE OF DEATH

02866

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb 75 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1/ Locust St.		d. STREET ADDRESS 201 Locust St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Bertha		First Bertha Middle May Last Robinson		4. DATE OF DEATH March 5, 1957		Month March Day 5 Year 19	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Sept. 4, 1880	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Public School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Teacher		11. BIRTHPLACE (State or foreign country) Dorchester Co.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Everett Robinson		14. MOTHER'S MAIDEN NAME Sarah Montgomery					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Mrs. E.M. Layton, Cambridge, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Palmonary Embolism		DUE TO Coronary thrombosis		DUE TO Arteriosclerotic CVD complete block		INTERVAL BETWEEN ONSET AND DEATH Instantly	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. Heart Valvular dysfunction 2 weeks						Mar 4, 57	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f (City or town) (County) (State)			
21. I certify that I attended the deceased from Mar 1, 1957 to Mar 5, 1957 7:45 A M, that I last saw the deceased alive on Mar 4, 1957 , and that death occurred at M , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Cambridge, Md.		DATE SIGNED Mar 7, 1957	
ACTUAL SIGNATURE James L. Thompson		PHYSICIAN'S NAME (Type) M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF Mar. 7, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Cambridge Cemetery		22d. LOCATION (City, town, or county) Cambridge, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Shoumas		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE, 3/11/57		24b. REGISTRAR'S SIGNATURE John Mace Jr.	

DUKEAU V. S

17-2054-1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02864 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02868
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Hoopersville	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hoopersville		b. COUNTY Dorchester	
c. LENGTH OF STAY IN 1b 1/1		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hoopersville Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Roadside House		d. STREET ADDRESS None	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Sangston		First Maddie	Middle Rose
4. DATE OF DEATH March 9 1957		Last 9	Month March
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Feb. 12, 1913		9. AGE (In years last birthday) 44 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Ross		14. MOTHER'S MAIDEN NAME Ida T. Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 216-01-6201	
17. INFORMANT William Ross--Hoopersville-Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ex. 0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		Acute Heart failure ?	
		Exhaustion ?	
		Acute alcoholism ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		DATE SIGNED 3/11/57	
ACTUAL SIGNATURE <i>John Mace Jr.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John Mace Jr.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 3/11/57		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Hoopersville Md.	
22d. LOCATION (City, town, or county) Dorchester Md.		23. FUNERAL DIRECTOR'S SIGNATURE LEON WHENRY CAMB. Md.	
24a. REC'D BY REGISTRAR DATE 3/11/57		24b. REGISTRAR'S SIGNATURE John Mace Jr.	

BUREAU V. A.

MAR 4 1957

REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02862 CERTIFICATE OF DEATH

02869

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <u>Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN lb <u>Call his life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hosp.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>	
3. NAME OF DECEASED (Type or print) <u>Frederick Ruark</u>		d. STREET ADDRESS <u>201 Glasgow</u>	
4. DATE OF DEATH <u>March 18</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 3, 1871</u>	
9. AGE (In years last birthday) <u>85</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11. IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mercantile</u>	
10c. BIRTHPLACE (State or foreign country) <u>Maryland</u>		14. MOTHER'S MAIDEN NAME <u>✓</u>	
15. FATHER'S NAME <u>Major Ruark</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Son - Henry Ruark</u>		Address <u>201 Glasgow St.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <u>122.2</u>			
(b) <u>Arterio-Sclerosis generalized</u>			
DUE TO <u>Malnutrition - Chronic Brain Syndrome</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Underlying Sub acute infection</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>None</u> 19 p. m. <u>None</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I attended the deceased from <u>Feb 26, 1957</u> to <u>March 18, 1957</u> that I last saw the deceased alive on <u>March 18, 1957</u> , and that death occurred at <u>5:10 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>Edwin Bradford</u> M.D. PHYSICIAN'S NAME (Type) <u>Edwin J. Bradford</u>		ADDRESS (Street, city or town, state) <u>Cambridge, Md.</u> DATE SIGNED <u>—</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL Mar 21, 1957</u>		22b. DATE THEREOF <u>Mar 21, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORIAL <u>Dor. Mem. Park</u>		22d. LOCATION (City, town, or county) <u>Cambridge, Md.</u> (State) <u>—</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service - Cambridge, Md.</u>		ADDRESS <u>—</u>	
24a. REC'D BY REGISTRAR <u>John Macph.</u>		24b. REGISTRAR'S SIGNATURE <u>John Macph.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CREAU V. S.

AR 22 1977

CREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04021

02847

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 2 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East New Market - Rural				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital				d. STREET ADDRESS Thompsonstown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Sarah		First	Middle	Last	4. DATE OF DEATH March	Month	Day	Year 1957
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 7, 1880	9. AGE (In years lost birthday) 76 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Isaac Molock			14. MOTHER'S MAIDEN NAME Frances Nichols					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Algie Sampson, East New Market, Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerotic heart disease (c)						INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Anemia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o.m. p.m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.D.	(County)	(State)		
21. I certify that I attended the deceased from 24 October, 1955, to 30 March, 1957, that I last saw the deceased alive on March 30, 1957, and that death occurred at 2:55 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 227 Pine St-Cambridge, Md. -4-2-57 DATE SIGNED								
ACTUAL SIGNATURE <i>J. Edwin Fassett</i>		PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 2, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Reid's Grove Cemetery	22d. LOCATION (City, town, or county) Near Rhode Island, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland			24a. REC'D BY REGISTRAR DATE 4/5/57	24b. REGISTRAR'S SIGNATURE <i>John MacP</i>				

BUREAU V. A.

APR 11 1967

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02870

02848

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md.		c. LENGTH OF STAY IN 1b 1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md.		d. STREET ADDRESS 300 Locust St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md. Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Sadie	Middle Parks	Last Schaffer	4. DATE OF DEATH March 2, 1957	Month March	Day 2	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH April 19, 1879	9. AGE (In years last birthday) 77 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. Hrs 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Cambridge, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George S. Parks				14. MOTHER'S MAIDEN NAME Mary Jane Meekins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Mildred LeCompte		Address Cambridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure DUE TO 570.2 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Myocardic Thrombosis DUE TO (c) Generalized Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 16 hours							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Residual RT Hemiplegia							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 9710		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9710 , 1944, to 31/12/1951 , that I last saw the deceased alive on 31/12/1951 , and that death occurred at 3:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. H. Hanks				ADDRESS (Street, city or town, state) 104 Locust St., Cambridge, Maryland			
DATE SIGNED 1/6/57							
22a. BLR AL. CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 5, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Mem. Park		22d. LOCATION (City, town, or county) (State) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service				ADDRESS Cambridge, Md.			
24a. REC'D. BY REGISTRAR 1/6/57				24b. REGISTRAR'S SIGNATURE John Mace, Jr.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate is signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

BUREAU V. S.

MAR 8 1957

RECEIVED

1
 HOSPITAL ■ ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 File No. 7,17451
CERTIFICATE OF DEATH

02941
 116
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY DORCHESTER		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE		b. COUNTY Wicomico	
c. LENGTH OF STAY IN 1b 3 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARDELLA	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CAMBRIDGE MARYLAND Hosp. Inc.		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JOHN	Middle W.	Last SMITH
4. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-29-77
9. AGE (In years from birthday) yrs 79	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Year 1957
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY OWN FARM	
11. BIRTHPLACE (State or foreign country) MISSOURI		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME POWHATEN SMITH		14. MOTHER'S MAIDEN NAME MARY DUMDEE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT rs. Flossie M. Smith		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-VASCULAR RENAL DISEASE	
DUE TO 44a		INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) (c)			
DUE TO 44a			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 27 MAR. 1957 to 30 MAR. 1957 that I last saw the deceased alive on 29 MAR. 1957 , and that death occurred at 5:35 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Walter E. Gunby Jr.			
PHYSICIAN'S NAME (Type) WALTER E. GUNBY JR.		22d. LOCATION (City, town, or county) (State) LAUREL, Del.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF MAR 31, 1957	
22c. NAME OF CEMETERY OR CREMATORIAL OPO Fellows Crem.		22d. LOCATION (City, town, or county) (State) LAUREL, Del.	
23. FUNERAL DIRECTOR'S SIGNATURE H. L. Disharoon, Laurel, Del.		24a. REC'D BY REGISTRAR DATE 1957	
		24b. REGISTRAR'S SIGNATURE John Mee, Jr.	

RECEIVED

APR 9 1957

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PH3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

02865 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02871

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		b. COUNTY Dorchester	
c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Cambridge	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 61 Park Lane		d. STREET ADDRESS 61 Park Lane	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF (Type or print) Mary		First Etta	Middle Stafford
4. DATE OF DEATH March 17 1957		Last 27 yrs.	Month Day Year
5. SEX female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6-28-1929
9. AGE (In years from birthday) 100 yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Dor-Co-Md.	
11. BIRTHPLACE (State or Foreign country) Dor-Co-Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Amos Stafford		14. MOTHER'S MAIDEN NAME Mary Etta Edphas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Joseph Amos Stafford-61 Park Lane-Camb.		Address Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis DUE TO 4-92 X Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause first. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>John Macph</i>		DATE SIGNED 3/23/57	
EXAMINER'S NAME (Type) Dr. John Macph Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		22b. DATE THEREOF 3-21-57	
22c. NAME OF CEMETERY OR CREMATORIUM Rock Cemetery		22d. LOCATION (City, town, or county) (State) Rock-Dorchester-Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert St. Clairs High St. Camb. Md.</i>		ADDRESS 24a. REC'D BY REGISTRAR DATE 3/23/57	
		24b. REGISTRAR'S SIGNATURE <i>John Macph</i>	

BUDEAU V. S

MAR 10 1972

LIBRARY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02866

CERTIFICATE OF DEATH

Reg. Dist. No.

02872

1. PLACE OF DEATH a. COUNTY Dorchester		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 4 months		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Delaware Maryland		b. COUNTY Talbot	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glasgow Convalescent Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beverly Easton		d. STREET ADDRESS South Aurora Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First AGNES	Middle LEAH	Last STEWART	4. DATE OF DEATH March 12 1957	Month March	Doy 12	Year 1957		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11-14-1872	9. AGE (In years from birth) 84 yrs.	10. IF UNDER 1 YEAR Months 84	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Samuel Thomas Stewart				14. MOTHER'S MAIDEN NAME Anastasia Richardson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Glasgow Convalescent Home Records, Cambridge, Maryland		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO <i>400.1</i>									
b) Coronary Sclerosis 3 months + DUE TO									
c) Arteriosclerotic cardio vascular renal disease 3 months + DUE TO									
d) with congestive failure 3 months +									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Adeno-carcinoma of breast, left, with operation									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour o. m. p. m. ---	Month January	Doy 8	Year 1957	20d. INJURY OCCURRED White Not white at work <input checked="" type="checkbox"/> <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	20f. (City or town) ---	(County) ---	(State) ---	
21. I certify that I attended the deceased from January 8, 1957 to March 12, 1957 that I last saw the deceased alive on March 7, 1957 , and that death occurred at 5:50 A.M. from the causes and on the date stated above.								ADDRESS (Street, city or town, state) 15 Locust Street, Cambridge, Md.	DATE SIGNED 3-13-57
ACTUAL SIGNATURE <i>Eldridge H. Wolff</i>									
PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 3-14-57	22c. NAME OF CEMETERY OR CREMATORIUM Springhill Cemetery			22d. LOCATION (City, town, or county) Easton			(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Clark Funeral Home				ADDRESS Easton, Maryland		24a. REC'D BY REGISTRAR DATE 3/16/57	24b. REGISTRAR'S SIGNATURE <i>John Macay Jr.</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

BUREAU V. E.

110-1000

REGISTRATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02850

CERTIFICATE OF DEATH

Reg. Dist. No.

02873

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Md Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Baby Boy	First	Middle	Last Thompson		
4. DATE OF DEATH 3	Month 3	Day 6	Year 1957		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-6-57		
9. AGE (In years from birthday) yrs 0	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0		
13. FATHER'S NAME James Brummell	14. MOTHER'S MAIDEN NAME Evangeline Thompson				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —	16. SOCIAL SECURITY NO. —	17. INFORMANT Essie Thompson-Cambridge, Md.	Address —		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis DUE TO Kid's Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Prematurity (b) DUE TO (c)					
INTERVAL BETWEEN ONSET AND DEATH —					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) —	(County) —	(State) —
21. I certify that I attended the deceased from March 6, 1957 , to March 6, 1957 , that I last saw the deceased alive on March 6, 1957 , and that death occurred at — M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) —					
ACTUAL SIGNATURE <i>J. Edwin Fassett</i>	DATE SIGNED 3-9-57				
PHYSICIAN'S NAME (Type) J. Edwin Fassett	M.D. 227 Pine St-Cambridge, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-9-57	22c. NAME OF CEMETERY OR CREMATORIUM Salem Cemetery	22d. LOCATION (City, town, or county) Salem, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Herb M. Sollman</i>	ADDRESS 227 Pine St-Cambridge, Md.	24a. REC'D BY REGISTRAR DATE 3/11/57	24b. REGISTRAR'S SIGNATURE <i>John Mace Jr.</i>		

BUZAU V. 2

PERGAMON

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02867 CERTIFICATE OF DEATH

02874

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woolford Md.		c. LENGTH OF STAY IN 1b 22 Ye ars		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woolford Md.		d. STREET ADDRESS Woolford Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Woolford Md.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elizabeth	First	Middle	Last	4. DATE OF DEATH March	Month	Day	Year 13, 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 15, 1872	9. AGE (In years last birthday) 84	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Church Creek Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Asbury D. Jones				14. MOTHER'S MAIDEN NAME Sarah Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Edwin Bramble		Address Woolford Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) LEFT CEREBRAL HEMORRHAGE CEREBRAL ARTERIOSCLEROSIS GENERALIZED ARTERIOSCLEROSIS INTERVAL BETWEEN ONSET AND DEATH 2 days.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) SENILITY.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 104 LOCUST ST.	(County) Cambridge
21. I certify that I attended the deceased from 3/13, 1957, to 3/13, 1957, that I last saw the deceased alive on 3/13, 1957, and that death occurred at 9 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 104 LOCUST ST. Cambridge, Maryland ACTUAL SIGNATURE W. H. HANKS PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 16, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Old Trinity Church		22d. LOCATION (City, town, or county) Church Creek	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE 3/14/57		24b. REGISTRAR'S SIGNATURE John Mace Jr.	

HOSPITAL OR ATTENDANT PHYSICIAN: This law requires that the death certificate be submitted within 24 hours after death: Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician.
 page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

200 V. S.

1951

SHANE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02868 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02875

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PAA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Dorchester		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY Dorchester	
Church Creek		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. LENGTH OF STAY (In lb)		d. STREET ADDRESS	
Life		/	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
Keath Elvis Yuvonne Travers			
4. DATE OF DEATH		Month	Day
Mar. 16, 1957			
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
Male		Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday)	
Jan. 8, 1957		10. IF UNDER 1 YEAR yrs.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
None		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Vernon Molock		Julvadie Travers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
No		17. INFORMANT	
		None	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Toxemia	
H75X			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Acute respiratory infection	
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		DATE SIGNED	
ACTUAL		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		3/17/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/18/1957	
22c. NAME OF CEMETERY OR CREMATORIALY Linas Road		22d. LOCATION (City, town, or county) (State) Linas Road, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert H. St. L. Mace Jr.		24a. REC'D BY REGISTRAR DATE 3/18/57	
ADDRESS Cambridge, Md.		24b. REGISTRAR'S SIGNATURE John Mace Jr.	
2067257			

BUREAU # 6

MAR 22 1968

U.S. GOVERNMENT
PRINTING OFFICE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02853 CERTIFICATE OF DEATH

02876

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Dorchester</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE <i>Maryland</i> b. COUNTY <i>Dorchester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Woolford</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Woolford</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>ADA</i>	Middle <i>NEAL</i>	Last <i>WHEATLEY</i>
4. DATE OF DEATH	Month <i>March</i>	Day <i>9</i>	Year <i>1957</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 15, 1914</i>
9. AGE (In years from birth) <i>72 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i> Min <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>John H. Neal</i>		14. MOTHER'S MAIDEN NAME <i>Josephine Wheatley</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mrs. Florence Neal Mills, Woolford, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of stomach</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Unknown</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <i>Malnutrition</i>		141 1 yr. 6 mos.	
DUE TO (b) <i>Partial obstruction stomach</i>			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Active - chronic generalized</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <i>6 p.m.</i> 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <i>Cambridge, Md.</i> (State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>Jan. 8</i> , 1956, to <i>Mar. 9</i> , 1957, that I last saw the deceased alive on <i>Mar. 8</i> , 1957, and that death occurred at <i>11:30 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Cambridge, Md.</i> DATE SIGNED <i>Mar. 11, 1957</i>			
ACTUAL SIGNATURE <i>James U. Thompson</i>		M.D.	
PHYSICIAN'S NAME (Type) <i>James U. Thompson</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Mar. 12, 1957</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Hollywood</i>		22d. LOCATION (City, town, or county) <i>Harrington, Del.</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>(Mrs.) R. H. Boyer, Harrington, Del.</i>		ADDRESS	
		24a. REC'D BY REGISTRAR DATE <i>3/11/57</i>	
		24b. REGISTRAR'S SIGNATURE <i>John Mace Jr.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02877

02870

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville 22-1072				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) LAURA AMANDA		First	Middle	Last	4. DATE OF DEATH March 20	Month	Day	Year 19 57
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6/30/74	9. AGE (In years last birthday) 82 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pittsville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Hiram Dennis		14. MOTHER'S MAIDEN NAME Mathilda Littleton						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Mae Downs—Pittsville, Maryland Eastern Shore State Hospital records				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage						INTERVAL BETWEEN ONSET AND DEATH 6 days		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		Cerebral arteriosclerosis						
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>March 17, 1956</u> , to <u>March 20, 1957</u> , that I last saw the deceased alive on <u>March 20, 1957</u> , and that death occurred at <u>12:10 PM</u> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <u>Thomas J. Dredge</u>				ADDRESS (Street, city or town, state) <u>State Hospital</u>		DATE SIGNED <u>3-20-57</u>		
PHYSICIAN'S NAME (Type) <u>Thomas J. Dredge</u>				Eastern Shore State Hospital—Cambridge, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 23, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Line Church Cemetery		22d. LOCATION (City, town, or county) Near Pittsville, Maryland		(State)
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY FUNERAL HOME — SALISBURY, MD.		ADDRESS		24a. REC'D BY REGISTRAR DATE <u>3/23/57</u>		24b. REGISTRAR'S SIGNATURE <u>John Macauley</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S

MAR

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02871 CERTIFICATE OF DEATH

Reg. Dist. No.

02878

1. PLACE OF DEATH a. COUNTY Dorchester		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb 55 years		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 207 Boundary Ave.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Cambridge		d. STREET ADDRESS 1 207 Boundary Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Jennie		First Ethel		Middle Wroten		4. DATE OF DEATH March 15, 1957		Month 19	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 12, 1883		9. AGE (In years lost birthday) 73 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Brookview, Dor. Co.		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME William F. Collison		14. MOTHER'S MAIDEN NAME Sarah Bassett							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No		16. SOCIAL SECURITY NO. No		17. INFORMANT 214-078787		Address Ethel Cannon, 207 Boundary Ave., Cambridge, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 600.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		DUE TO (b) Myocarditis		Thyocardial Failure		INTERVAL BETWEEN ONSET AND DEATH 2 days			
DUE TO (c) Aplastic Anemia		Thyelonephritis, acute		4 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Aplastic Anemia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 3/15/57		(County) (State)	
21. I certify that I attended the deceased from _____, 19_____, and that death occurred at _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____, M, from the causes and on the date stated above. ACTUAL SIGNATURE W. H. Hanks		ADDRESS (Street, city or town, state) 104 Locust CAMBRIDGE Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Mar. 17, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Greenlawn Cemetery		22d. LOCATION (City, town, or county) Cambridge		(State) Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Thomas, Cambridge, Md.		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE 3/20/57		24b. REGISTRAR'S SIGNATURE John MacL.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 8
RECEIVED
MAR 26 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02851

CERTIFICATE OF DEATH

02879

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge - Maryland Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna	
3. NAME OF DECEASED (Type or print) Samuel		First J.	Middle Young
4. DATE OF DEATH March 17 1957		5. SEX Male	6. COLOR OR RACE Colored
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 25, 1885	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Carpenter	
11. BIRTHPLACE (State or foreign country) East New Market, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lewis Young		14. MOTHER'S MAIDEN NAME Mary Etta Jackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Lavinia J. Young, Vienna, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Cardiac Decompensation		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerotic heart disease			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 1957, to March 17, 1957, that I last saw the deceased alive on March 17, 1957, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>J. Edwin Fassett</i>		DATE SIGNED 22. M.D. 227 Pine St-Cambridge, Md.-3-21-57	
PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF March 21, 1957		22c. NAME OF CEMETERY OR CREMATORIAL East New Market Cemetery	
22d. LOCATION (City, town, or county) East New Market, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR DATE 3/23/57	
VS A1S (4) 1SM 9/55		24b. REGISTRAR'S SIGNATURE <i>John MacL.</i>	

RECEIVED
BUREAU V. S.

MAR 29 1957